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A Case of Intra-Ligamentous Ovarian Cyst;

GENERAL PERITONITIS; UNIVERSAL ADHESIONS; OVARIOTOMY; RECOVERY.

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FORMERLY PROFESSOR OF ANATOMY IN THE KENTUCKY SCHOOL OF MEDICINE, ETC.

A Paper read before the Central Kentucky Medical Association.

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A CASE OF INTRA-LIGAMENTOUS OVARIAN CYST; GENERAL PERITONITIS; UNIVERSAL ADHESIONS; OVARIOTOMY; RECOVERY.

In previous reports of cases of ovariotomy to this Society I have described the technique of the operation, and discussed points relating to the diagnosis and pathology of ovarian tumors. So much has been written of late upon this subject, and such brilliant results have been obtained by many operators, that an eminent authority suggests the idea that the last words are said upon the subject. While this degree of perfection may apply to a few expert operators working amid the dense population of certain European countries, the subject of ovariotomy cannot be regarded "a closed chapter" by the profession of the United States, where a large population is scattered over a vast area and the work necessarily distributed among a large number of operators. Hence I make no apology for reporting in detail the following difficult and complicated case, illustrating, as it does, so many important points in advanced abdominal surgery.

On November 18, 1886, I was called to Williamsburgh, Ky., by Dr. E. S. Moss, of that town, to see Mrs. G. W., aged 29 years, the mother of six children, the youngest being 3 years of age. The patient was confined to her bed, vomiting daily, and suffering severely from the effects of intra-abdominal pressure. The tumor was first observed two years ago. Six weeks previous to my visit she was tapped and a large quantity of fluid drawn off. This was followed by a severe attack of general peritonitis, the temperature ranging above 105° F., during which her life was almost despaired of by her physician. Three

weeks before my visit she was tapped the second time, and the fluid again rapidly accumulated. A careful physical examination confirmed the diagnosis and suggested extensive adhesions.

The operation was performed at 11 o'clock on Thursday, November 18, 1886, the following gentlemen being present: Drs. E. S. Moss, Gatliff, Watkins, Parker, Blain, and Ellison. Dr. Gatliff administered ether, and Dr. Moss kindly assisted me throughout the operation. On making the incision through the abdominal wall I found the peritoneum and cyst firmly adherent, and dividing this layer the tumor was opened. Turning the patient on her side a large portion of the contents was discharged. Introducing my hand, the tumor was found to be multilocular; the additional compartments were torn open and emptied. At this stage of the operation I was first able to appreciate the immense size of the cyst and the extent of adhesion. Only three weeks having elapsed since the last tapping, and the fluid not having fully refilled the sac at the time I saw the patient, I had failed to realize the immense size of the sac. I now discovered that the tumor extended from Douglas's cul-de-sac to the diaphragm, and that the adhesions were absolutely universal.

Being unable to evert the sac, I sought for some unattached point through which I might gain entrance to the peritoneal surface and remove the cyst by enucleation. In this I failed, for the preceding peritonitis had firmly fused the peritoneum and cyst wall, leaving no unattached point. To determine this point thoroughly I enlarged the incision from three to about five inches. Finding it impossible to gain an entrance by an unattached point, I began the dissection of the cyst with scalpel and forceps at the edge of the incision. I succeeded in getting "a hold" in this way, and proceeded cautiously, but as rapidly as I could, in the work of enucleation. I stripped the cyst from the pelvis, the bladder, and the whole

surface of the womb, from the ascending, transverse and descending colon. I then stripped the small intestine and omentum from the cyst. The latter was extensively and firmly adherent, and required a number of ligatures. I was careful to avoid injury to the ureters on each side, an accident not unknown in such cases, and, of course, one of the utmost gravity. The lower portion of the cyst I found included between the folds of the broad ligament, and had to be carefully enucleated. The tumor sprang from the right side. When all the adhesions were separated the tumor came away without a pedicle. The left ovary was found to be normal, and hence was not removed.

The toilette of the peritoneum was tedious and exacting; many bleeding points had been secured with forceps and many were ligatured. After securing all bleeding points, the abdomen was washed out with pure warm water, and I began the introduction of the parietal sutures. At this stage of the operation the patient's pulse became very rapid and feeble, and, assisted by the gentlemen already named, I placed her in bed, injected brandy beneath the skin in several places, and surrounded her with bottles of hot water. Through the lower angle of the wound I then passed a Keith's glass drainage-tube, and tied the stitches closing the incision. The surface of the abdomen being thoroughly cleansed and dried, the wound was dressed with antiseptic gauze, and a bandage applied. The drainage-tube was secured in place in the usual way, and its external opening protected with sponge and rubber sheeting. The entire operation occupied fifty-eight minutes.

The patient occupied a room to which she had been removed from her home in the country, and which had been carefully cleansed, dried and prepared for the purpose. The bed, mattrass and clothing were new, and everything used was scrupulously clean. I will not describe the details of preparation

of sponges, instruments and dressings, as it would be a mere repetition of previous reports made by me to this Society. I will only say that I continue to use a solution of carbolic acid, strength of 1 to 40, for the instruments and sponges, and for sutures and ligatures the best silk; and that I spare no pains in my endeavor to secure perfect cleanliness of operator, assistants, and everything coming in contact with the patient. I believe that the faithful application of the *principles* of the Listerian system is the only sure method of attaining good results after laparotomy. As to whether asepsis is attained by carbolic acid, corrosive sublimate, iodoform, hot water, or other agents, is unimportant; the principles of Listerism are essential, though the manner of their application may vary with the fancy of various operators.

The attending physician in this case was Dr. E. S. Moss, of Williamsburgh, an accomplished young practitioner, formerly an *interne* in the Louisville City Hospital. He assumed the management of the case the second day after the operation, and conducted the after-treatment. We were in daily communication by letter and telegraph. From his notes kindly sent me, I condense the following history of the progress of the case after the operation:

The shock of the operation was severe, and reaction came about rather slowly. During the first three days all went smoothly, the temperature and pulse ranging about 100. The catheter was required to relieve the bladder. On the third day, the discharge from the drainage-tube having about ceased, the tube was removed and the edges of the wound brought firmly together. On this day, also, there being some distension, an enema of warm water was administered, which brought away fæces and gas.

On the fifth day the pulse was over 120, and the temperature reached 104° F., with general symptoms corresponding. Being apprised of the situation, I telegraphed Dr. Moss to open the wound, wash out

the peritoneal cavity, and retain the drainage-tube in place, which was promptly done. I also suggested the administration of a brisk cathartic, and Dr. Moss gave a dose of calomel and jalap, which acted freely and promptly. Our efforts were rewarded by the temperature falling below 100° F., with corresponding improvement in all the symptoms. The patient continued to progress satisfactorily for a number of days, and the tube was again removed.

On December 10, the twenty-second day after the operation, the temperature again ascended, reaching 103° F., with rapid pulse and rather alarming symptoms. Dr. Moss again opened the lower angle of the wound, found a parietal abscess, introduced a rubber drainage-tube, and washed out the abscess cavity. The improvement was prompt, but the discharge persisted until December 19, when, having altogether ceased, the tube was removed and the wound allowed to close. On December 26 the patient sat up, and she improved rapidly from that time on. The following letter from Dr. Moss, dated February 1, 1887, announces her prompt recovery:

Dear Doctor:—Enclosed I send you notes of Mrs. W.'s case from the day you left, and hope you will place them in such form as you think best. I ceased to visit her regularly on January 9, as she was then going about the house. She has completely recovered and has returned to her home, six miles in the country. Her husband informs me that she has reached her usual standard of strength and flesh, and is daily attending to her household duties. Very respectfully, E. S. Moss.